Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

In the Matters of	)	
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Promoting Telehealth for Low-Income Consumers	)	WC Docket No. 18-213
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COMMENTS OF MERCY VIRTUAL

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EXECUTIVE SUMMARY

Mercy Virtual, a division of Mercy ACO Providers' Services, is a leading telehealth and connected care provider in the United States through its first-of-a-kind Virtual Care Center that offers remote and rural patients round the clock access to Mercy's network of bedside clinicians, primary care providers, and specialists. Mercy Virtual shares its decade-plus experience providing telemedicine and connected care monitoring to help the Commission better understand the costs of telemedicine and structure the Connected Care Pilot to maximize patient benefits. Currently, Mercy Virtual's vEngagement program, which provides in-home remote patient monitoring with goals similar to the goals of the Commission's Pilot, has increased targeted health care interactions during clinic visits by 16 percent, lowered hospitalizations by 50 percent, and lowered costs by 30 percent. Through this experience, Mercy Virtual provides targeted responses to the Commission's Notice of Proposed Rulemaking.

Mercy Virtual recommends focusing on patients with complex chronically ill conditions (roughly 153.2 million adults) and those with behavioral (mental) health conditions (roughly 48.26 million adults) that will provide a broad potential patient base for pilot programs. Further, providing funding for broadband connectivity as well as certain patient devices will be necessary to maximize the benefits of the pilot programs, given that current Medicare and health insurance reimbursement practices do not cover these types of costs. To ensure the greatest benefit from the pilot programs, the Commission should limit eligibility to experienced telehealth providers with a physical presence in the proposed service area. However, Mercy Virtual recommends a secondary, post-application process during the ramp-up period that will select broadband network structure following patient identification. By designing the broadband network/connectivity solutions following patient identification, health care providers can tailor broadband network design to the needs of participating patients, increasing administrative

efficiency and providing more accurate information to the Commission. Finally, Mercy Virtual supports clear goals and performance measures, but requiring controlled clinical trials will increase administrative costs unnecessarily as health care providers regularly evaluate the benefits of telemedicine through reporting metrics like length of stay, hospitalization rate, repeat admission rate, emergency visits, and costs savings.

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Mercy Virtual, a division of Mercy ACO Providers' Services ("Mercy"), provides these comments in response to the Federal Communications Commission's ("FCC" or "Commission") Notice of Proposed Rulemaking ("NPRM") in the above-referenced proceeding.[1] Mercy applauds the Commission's efforts to establish a pilot program to support telehealth and connected care programs. Mercy provides detailed responses to further the Commission's goals and help establish this initial pilot. Specifically, Mercy shares its experience in telemedicine to identify health conditions most suitable for treatment under the program; direct funding to broadband services, equipment, and network costs where it is most needed; design efficient and effective program structure; and, incorporate clinical trials as part of the Commission's performance measures.

I. Background of Mercy Virtual Care

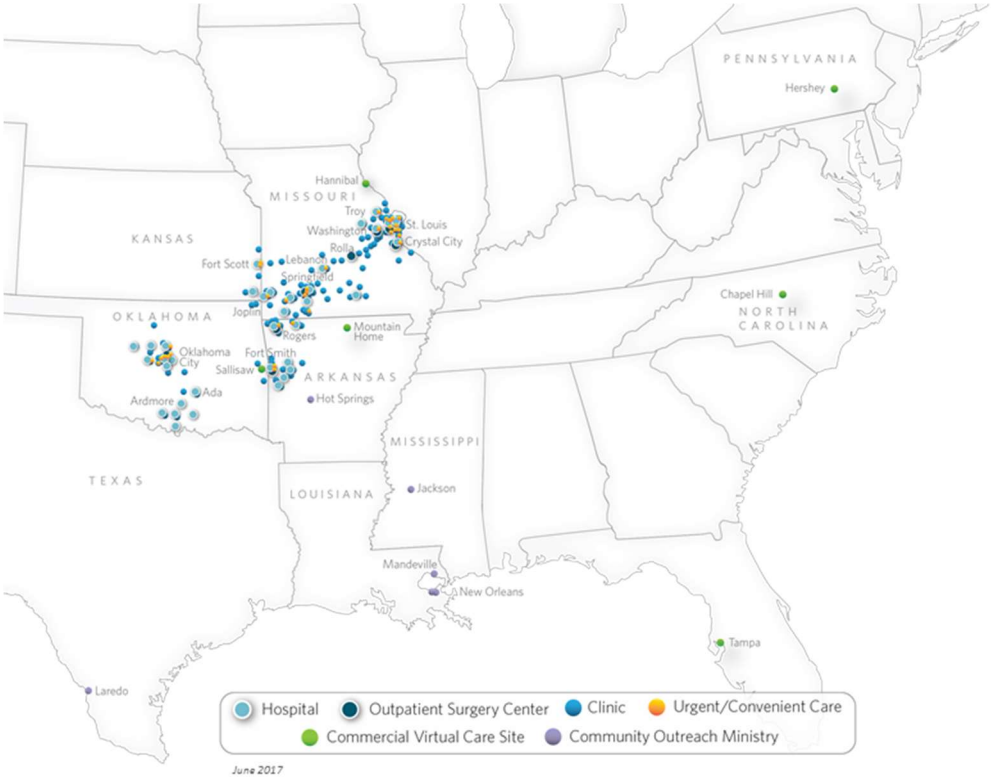
Mercy Virtual is a leading telehealth and connected care provider founded by the Sisters of Mercy.[2] For nearly 200 years, Mercy has provided health care to people most in need. Mercy truly lives out its mission statement: "As the Sisters of Mercy before us, we bring to life the healing

[1] *Promoting Telehealth for Low-Income Consumers*, Notice of Proposed Rulemaking, WC Docket No. 18-213, FCC 19-64 (2019) (*Connected Care NPRM*).

[2] Mercy is a large top ranked healthcare provider with operations across several states in the Midwest and South. Mercy was originally founded as the House of Mercy in 1827 operated by the Sisters of Mercy, one of the world's first religious orders devoted to caring for the poor, sick, and uneducated. The Sisters of Mercy Health System transitioned its name to Mercy in 2011. Today, Mercy is ranked as the fourth largest medical group in the United States by SK&A, a top American employer by Forbes, and one of the Elite 100 finalists by InformationWeek for Mercy's information technology. *See* Mercy, *Transforming the Health of Our Communities*, https://www.mercy.net/about/transforming-the-health-of-our-communities/ (last visited Aug. 29, 2019).

ministry of Jesus through our compassionate care and exceptional service" and its values of dignity, service, justice, excellence, and stewardship. Today's Mercy is now one of the largest health care providers in the United States with more than 40 acute care, managed and specialty (heart, children's, orthopedic and rehab) hospitals, 900 physician practices and outpatient facilities, 45,000 co-workers and 2,400 Mercy Clinic physicians operating clinics in Arkansas, Kansas, Missouri and Oklahoma. Mercy also maintains outpatient services and outreach ministries in Arkansas, Louisiana, Mississippi and Texas.

Overview of Mercy Services & Locations



Mercy Virtual is dedicated entirely to care outside its own walls, monitoring patients and providing health care 24 hours a day, seven days a week, 365 days a year using high-speed data and video connections and medically intervening when and where patients need it with a comprehensive team approach. At the center of this care model is the Mercy Virtual Care Center,

the world's first health care center with no patient beds dedicated to providing telehealth. The Virtual Care Center serves as a nationally recognized center for developing and delivering telehealth.[3] The Virtual Care Center offers a new way of proving patient centered care for patients through remote access to leading practitioners. It is also designed as a workspace for innovations in patient care and product testing. Mercy Virtual's telehealth model enables collaboration with bedside clinicians, primary care providers, and specialists to utilize patient data in real time. This collaborative approach enables Mercy Virtual and local providers to diagnose and intervene earlier, getting care to patients when and where they need it with less expense.

Currently, Mercy Virtual offers a continuum of solutions that are consciously designed to be scalable, replicable, and flexible enough for seamless adaptation and implementation in different contexts with different partners. These services include:

- vEngagement: supports the health care system's sickest patients in their homes under the direction of their primary care provider. The program uses a state-of-the-art remote monitoring kit, weekly touch points, and consistent implementation of the patient care plan.
- vKids: provides critical access to pediatric expertise and specialty care to children in remote or medically underserved areas.
- vHospitalist: supports the bedside team through real-time assessment, documentation, orders for tests and therapies, and efficient management of admissions and transfers. This decreases ER hold times, increases patient safety by reducing verbal orders and allows for rapid responses to patient needs.
- vICU: the largest single-hub electronic ICU in the nation. Through advanced analytics, enhanced visual technologies and tested processes, Mercy Virtual collaborates with bedside caregivers to provide optimal care for patients across seven states.
- vSepsis: screens all patients admitted to inpatient facilities for sepsis, then continuously monitors and tracks individual risk factors helping to prevent sepsis, which currently strikes one million patients each year, and reducing costs.

[3] "Mercy Virtual is arguably the world's most advanced example of something gaining momentum in the health care world: A virtual hospital, where specialists remotely care for patients at a distance. It's the product of converging trends in health care, including hospital consolidation, advances in remote-monitoring technology and changes in the way medicine is paid for. Politico, *A Hospital Without Patients*, https://www.politico.com/agenda/story/2017/11/08/virtual-hospital-mercy-st-louis-000573 (Nov. 1, 2017).

- vMental Wellness: provides training and assessment tools that help primary care physicians and pediatricians recognize the signs of mental distress and treat the conditions – and provides access to specialists who can provide immediate care in real time.
- vAlert: centralized telemetry (EKGs and pulse oximeters) that allows staff to keep constant watch on patients' vital signs for fluctuations and warn floor staff immediately.
- vStroke: connects Mercy's neurologists with local emergency physicians through two-way video and, using the patient's electronic health record, enables collaboration to diagnose strokes quickly.
- Care Management: provides integrated general health and wellness services to workforce employees to improve and maintain employee health.
- vSitter: provides continuous, 24/7 observation of at risk patients, using a two-way audio/video solution to redirect patient activity or behavior, preventing falls and adverse events.
- vConsult: connects specialists in oncology, neurology, cardiology, sleep medicine, and other specialties with patients and local care providers regardless of time and distance.
- vNurse on Call: provides around the clock access to health care advice through simple and convenient phone calls.
- vEmergency: serves Critical Access facilities in remote or underserved areas facing a lack of ER providers.

II. The FCC's Connected Care Pilot Program

The FCC proposes to launch a 3-year connected care pilot program funded with $100 million to facilitate the use of advanced telehealth technologies to reach medically underserved populations including low-income Americans and veterans. According to the NPRM, the Commission hopes to elicit additional information concerning connected care services provided to medically underserved populations that potentially can be used to shape funding programs it may adopt in the future. For that purpose, the Commission outlines four goals for the pilot program:

(1) improving health outcomes through connected care;

(2) reducing health care costs for patients, facilities, and the health care system;

(3) supporting the trend towards connected care everywhere; and,

(4) determining how USF funding can positively impact existing telehealth initiatives.[4]

Mercy chose to get involved in the connected care space thirteen years ago for these exact reasons. Mercy brings value in the integration of virtual solutions throughout the entire continuum of care – beyond the walls of the hospital, doctor's office, and home – creating the ability to more effectively impact and manage patient care end-to-end, seamlessly. Our virtual care teams augment the bedside and primary care teams to ensure continuity of care regardless of location or acuity.

Virtual Care directly alleviates some of the greatest challenges facing health care today through the Quadruple Aim Model:

ACCESS: Removes barriers to accessing quality health care;

EXPERIENCE: Addresses provider shortages from primary care to specialty including behavioral health;

COST: Reduces the overall cost of health care delivered; and

POPULATION HEALTH: Improves population health and outcomes.

Through its continuum of programs and services, Mercy Virtual has improved health care outcomes for patients and providers, as well as significantly decreased ER visits and repeat admissions. In this model of care, we have also relieved some of the burden to providers/clinicians which is a major concern for all health systems. Specifically to date, Mercy Virtual's vEngagement program has increased targeted health care interactions during clinic visits by 16 percent, lowered hospitalizations by 50 percent, and lowered costs by 30 percent. At the same time, patients report a 98 percent satisfaction rating resulting in 86 percent of patients making daily check-ins and 90 percent of patients arriving early or on time to scheduled visits.[5]

[4] *Connect Care NPRM*, para. 78.

[5] Mercy Virtual collects and analyzes performance data and costs for all of the programs described above in Section I, *supra*.

Based on Mercy Virtual's real-world experience providing connected care services, Mercy Virtual responds to specific issues raised in the Commission's *Connected Care NPRM*.

III. The Commission Should Focus on Complex Chronically Ill Health Conditions Along With Behavioral (Mental) Health Conditions

Mercy Virtual recommends that "health condition" be defined to mean complex chronically ill, chronic conditions, or behavioral (mental) health conditions. This broad definition of health condition should include, but not be limited to, the following specific areas of focus: opioid dependency, hypertension or stress, chronic heart failure, chronic obstructive pulmonary disease ("COPD"), diabetes, similar chronic diseases, anxiety, depression, schizophrenia, bi-polar, and post-traumatic stress syndrome. By adopting a specific definition of health condition and diagnoses, the Commission will safeguard against potential waste, fraud, and abuse concerns through funding programs with specific mandates to aid identified groups of people.[6] Further, the Center for Disease Control and Prevention estimates that 6 in 10 adults in the United States have a chronic disease such as heart disease, cancer, lung disease, stroke, Alzheimer's, diabetes or kidney disease (roughly 153.2 million adults in 2018).[7] In addition, the National Institute of Mental Health estimates that nearly 1 in 5 adults in the United States have a mental illness or recognized mental health condition (roughly 48.26 million adults in 2018).[8] Together these populations represent a significant number of individuals. Commission rules that direct pilot funding toward these populations will help to ensure that individuals in need benefit from the pilot and that the

[6] *Id.*, para. 18.

[7] Center for Disease Control and Prevention, *Chronic Diseases in America*, https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm (April 15, 2019).

[8] National Institute of Mental Health, *Mental Health Information*, https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part_154785 (Feb. 2019).

Commission will have access to the ample data and feedback that should be made available from services provided in the connected care pilot program.

IV. The Commission Should Support Broadband Connectivity for Both the Patient and Participating Care Provider

The Commission asks several questions about current connected care and telehealth services and how best to use the pilot's funding to support health care providers and patient services.[9] Mercy Virtual is constantly evaluating the usability and viability of new products in the marketplace. Mercy Virtual actively pursues innovations in remote patient monitoring technologies/devices and all other telehealth programs. Mercy Virtual already has three and a half years' experience in remote patient monitoring in addition to several years in remote care. During this time, several barriers to telehealth and remote monitoring services have become evident.

The cost to stand up, implement, and utilize telemedicine is extremely high and serves as the primary barrier to adoption. In working to lower costs, Mercy Virtual has actively sought reimbursement from Medicare. However, Medicare understandably imposes numerous requirements and limitations to the coverage of expenses. Those requirements and limitations make Medicare reimbursement for new and innovative telehealth and connected services virtually impossible for many patients and health care providers.[10] Further, other insurance providers often adopt requirements and limitations similar to Medicare to ease their administrative burdens. This has caused a significant gap in what expenses are reimbursable versus the costs to provide telemedicine and remote patient monitoring. Another major barrier to adopting telehealth services is the lack of available technology and services in patient homes. In our experience, patients

[9] *Connected Care NPRM*, paras. 19-26.

[10] *See* Center for Medicare & Medicaid Services, *Telehealth Services*, at 3-4, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf (January 2019) (limiting reimbursement to specific rural identifiers and not allowing in-home delivery of service).

frequently do not have access to broadband services, do not have the necessary level/speed of connectivity, or adequate end-user devices for receiving care.

Accordingly, as outlined below, the pilot should promote a continuum of care model and not a single source of care connection. This means that health care providers that have a background in telehealth and have physical "brick and mortar" locations in proximity to patients should be considered for this program. In our experience, providers that *only* have a telehealth presence with no affiliated "brick and mortar" healthcare operations would create gaps in the effort for connected care. If a need for care arises that extends the ability of telehealth, it would be difficult to connect the patient to a local healthcare provider that understands the patient's medical history.

a. Pilot Funding Should be Made Available for End User Devices

The Commission proposes to make end user devices, medical devices, and mobile applications ineligible for support.[11] Currently, Mercy Virtual provides the funding for devices and supporting equipment used by patients without reimbursement. This is a substantial investment that Mercy Virtual has found to be necessary to increase the quality of care and life for patients. Given the slow adoption and recognition of connected care costs in the current insurance model, Mercy Virtual often must to build in device costs, like a tablet device, blood pressure cuff, pulse oximeter, weight scale, vitals monitoring patch, etc. into its connected care offerings to enable quality patient care while balancing economic considerations. In Mercy Virtual's experience, there is no other major source of reimbursement available to patients for these devices. Lack of reimbursement for these technology needs is often the primary barrier for getting patients the devices necessary for providing quality care. Along with the purchase price of such equipment,

[11] NPRM at Para 26.

some large costs include: logistics of telehealth equipment, software creation, and maintenance. To achieve the most beneficial care outcomes from funded pilot programs, the Commission should provide funding to offset or reduce the cost of needed remote monitoring devices.

Mercy Virtual chose to invest in the patients' best interests regarding funding patient devices with the anticipation that legislation or reimbursement would eventually catch up and promote funding these patient needs. Without device funding, Mercy Virtual is limited in its ability to provide telehealth care to the multitude of patients in need.

Even when a patient possesses a personal mobile device, such as a tablet or smartphone, challenges exist in utilizing the device due to differing mobile platforms, operating software version age, and the extent of broadband service capabilities of the patient's personal mobile device. Fragmentation and compatibility with every consumer device simply is not possible and these roadblocks cause telehealth providers to make tough choices of enhancing capabilities while reducing compatibility with older or lesser used devices. Further, the data requirements of telehealth monitoring services often, if not always, include continuous streaming of patients' biometric data, which requires certain minimum hardware requirements that older consumer devices may not meet. Given these considerations, in Mercy Virtual's experience, caring for a specific population of patients with chronic or complex issues requires a suite of coordinated and interoperable medical devices that often cannot utilize patients' personal mobile devices for data processing, transmitting and/or storage.

Relying on patients' existing devices such as smartphones or tablets can present challenges based on software interoperability and hardware limitations. Another material drawback to using patients' existing devices is that telehealth solutions typically require the transmission of a significant amount of data. This transmission can quickly exceed the limits of a patient's personal

wireless data plans. This is especially true for patients in medically underserved areas. For example, the average patient in a Mercy telehealth program used 1.5 GBs/patient/month to transmit and receive telehealth services. This usage increases for patients using wearable devices to 4 GBs/patient/month. While this data usage and the associated costs may be high, patient outcomes are dramatically improved when health status data is automatically monitored and transmitted. Remote monitoring allows health care providers ready access to patient status data and thus enables more efficient and effective patient-health care provider interactions focused on needed medical attention rather than the logistics of transmitting patient data.

b. Pilot Funding Should be Made Available for Network Equipment

Mercy Virtual supports the Commission's proposal to make funding available for "network equipment necessary to make a broadband service functional."[12] In the provisioning of broadband service for telehealth, consideration must be made to provide sufficient bandwidth to support the patient mobile device. Telehealth requires data heavy transmissions to support the delivery of multi-point, secure, high-performing live video interaction with little to no latency or jitter and provide continuous streaming of patient data from patient bio-sensors. Mercy Virtual recently completed an enterprise upgrade of its network, including Wi-Fi access, in its hospitals and clinics to enable the network infrastructure within the hospital or clinic to meet the expected needs of increased mobile and video usage. Simply put, modern telehealth services require robust network equipment to ensure service quality. However, the in-home and surrounding telecommunications network reality for patients most in need of telehealth services is that they often do not have access to necessary robust network infrastructure. In rural areas, lengthy and expensive Ethernet cables

[12] *Id.*, para. 24.

need to be run to homes to enable WiFi in that location in addition to the cost of WiFi routers and monthly recurring service costs.

To achieve quality broadband service, Mercy Virtual has used two broadband connectivity options: (1) build infrastructure and create a long-term broadband solution; or (2) use mobile 4G LTE broadband for a cost-effective, short-term solution. Since Mercy has begun investing in rural population health, there have only been a couple of scenarios where it made sense to build the infrastructure giving the patients' homes WiFi due to the lack of cellular availability in the area. Each of those infrastructure builds cost Mercy over $1,000 due to the length and complexity of the install. This option entails much higher initial costs, but ultimately is more sustainable and cost-effective for long-term coverage.

When building infrastructure does not make sense, Mercy Virtual pays on a per-device basis to provide broadband cellular access. This option is not always feasible due to poor or nonexistent wireless reception in remote and rural areas, but where it is possible, offers less expensive start-up costs. Regardless of delivery method, Mercy Virtual has incurred significant network equipment costs to provision its telehealth services. These costs naturally limit the coverage and utility of telehealth made available to patients in need and pilot funding would offer much-needed support that would provide direct and immediate benefits to patients and providers and ultimately lower costs of healthcare. Accordingly, the Commission should provide funding for necessary network equipment both at the health care facility and the patient's residence.

c. Care Providers' Current Costs

In Mercy Virtual's experience, telehealth providers fund the majority if not the total cost of broadband when service is provided to a patient's home. This results from the limited reimbursement and insurance coverage available for these services. This is an unsustainable business model. Despite a growing willingness to adopt innovative, new healthcare models that

can provide better, less expensive healthcare to patients in need, health care providers are forced to make difficult resource decisions when it comes to providing connected care services in circumstances where the necessary broadband transmission service, network and/or patient home equipment is limited. Mercy Virtual has limited its growth and number of patients served due to the costs of devices and broadband connectivity acquisition/maintenance. There are no other adequate forms of reimbursement or recovery to address these needs. Currently, Mercy Virtual is only aware of End-Stage Renal Disease ("ESRD") treatments being reimbursed for in-home service delivery. This leaves the entirety of other telehealth services unfunded by Medicare. This funding gap is compounded by the fact that other payers are slow to adopt coverage criteria different from Medicare.

With respect to Mercy Virtual's costs, when Mercy Virtual provides patient devices for in-home use, the tablet is "locked" so that the patient can use the device only to access the applicable healthcare applications. Mercy Virtual utilizes cellular-enabled devices for its chronic care program. Mercy Virtual incurs a costs ranging from of approximately $26/patient/month to $87/patient/month equaling close to $1 million per year in the aggregate for patient cellular charges or fixed WiFi associated with funded telehealth solutions. The device management, logistics, software compliance, and maintenance add substantial additional costs. Mercy Virtual's chronic condition program currently treats 2,700 patients. On a monthly basis with the current patient population, Mercy Virtual spends $66,012 on data services for the cellular enabled devices; $66,421 is spent on device kits and logistics. These amounts pertain only to the cellular service and in-home device expense and do not cover, the cost of actual healthcare.

When Mercy Virtual has utilized fixed broadband solutions, initial costs to deploy broadband to rural patients have been as high as $1,000 for a single broadband connection. Further,

in some instances, the costs of deploying fixed broadband to a patient location have been so high that the fixed broadband provider has denied Mercy Virtual's request to establish a connection.

Mercy Virtual focuses on cellular broadband due to the often poor fixed broadband coverage for its patients. This should come as no surprise to the Commission, as the Commission's recent Broadband Deployment Report shows 26.4% of rural Americans lack fixed broadband coverage.[13] In comparison, less than 1% of rural Americans lack mobile LTE coverage.[14] Considering the current broadband landscape, Mercy Virtual covers the cost of patient cellular service to deliver telehealth services. It is not a scalable model to provide private cost coverage of cellular service or broadband connectivity given the lack of service coverage and the growing need of patient care. Mercy Virtual supports the Commission's proposal to include funding for fixed and mobile broadband to the service provider of the participating health care provider's choosing.[15]

d. Duration of the Pilot

The Commission proposes that the pilot programs run for three years with two separate six month windows to ramp-up and ramp-down the selected programs.[16] Mercy Virtual supports this structure and believes selected pilots would be able to collect sufficient data in this time period to objectively gauge the value of the connected care program. In similar pilot programs or telehealth initiatives, Mercy Virtual already collects programmatic information. Typically, telehealth pilots last several months and in rare cases multiple years in order to have time to improve on data gaps and gather enough information to objectively judge the effectiveness of the pilot. The

[13] Federal Communications Commission, Broadband Deployment Report, 16, para. 33 (2019) https://docs.fcc.gov/public/attachments/FCC-19-44A1.pdf.

[14] *Id.* at 17-18, para. 35.

[15] *Connected Care NPRM*, paras. 19, 46-48.

[16] *Id.*, para. 35.

Commission's current structure would provide ample time to enroll initial patients and obtain statistically significant results.

However, the Commission should consider the effects of discontinuing support for broadband connectivity at the conclusion of the pilot. By supporting continued telehealth services for a period of three years, patients are likely to experience negative health care outcomes to losing service at the conclusion of the program. The Commission may want to consider an intermediate review of the program. The purpose of this review would be to consider if sufficient evidence has been presented to establish a permanent connected care fund prior to the conclusion of the pilot programs. This would afford the Commission the opportunity to continue supporting pilot programs where positive results have been empirically established.

V. The Commission Should Limit Eligibility to Experienced Telehealth Providers with Physical Presence in the Proposed Service Area

The Commission proposed to use the existing statutory definition of non-profit or public health care providers within section 254(h)(7)(B), which includes: (i) postsecondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (ii) community health centers or health centers providing health care to migrants; (iii) local health departments or agencies; (iv) community mental health centers; (v) not-for-profit hospitals; (vi) rural health clinics; (vii) skilled nursing facilities; (viii) and consortia of health care providers consisting of one or more entities described in clauses (i) through (vii).[17] Mercy Virtual supports the application of this definition to define eligible health care providers for the pilot program. Mercy Virtual encourages the Commission to adopt the proposal to limit pilot eligibility to health

[17] *Id.*, at para. 37; 47 U.S.C. § 254(h)(7)(B).

care providers that have a background in telehealth and have "brick and mortar" locations in proximity to patients.[18] Mercy Virtual has observed that providing telehealth services without a "brick and mortar" location create gaps in the quality and reliability of the "connected care" provided. Without the ability to bring patients into a local location, the health care provider is not able to provide the full continuum of care. Telehealth and connected care promotes proactive monitoring and management, but full patient care necessitates in-person interactions at appropriate times that require the participating health care provider to have some local presence.

VI. The Commission Should Design Applications to Consider Health Care Provider Qualifications While Permitting Flexibility in Network Design and Procurement

a. Application Process

The Commission proposes a detailed application process that may deter applicants from participating in the pilot program.[19] Mercy Virtual supports application requirements calling for information regarding the health care provider's experience and prior telehealth qualifications and believes the 120-day period would be sufficient for providing qualifications and pilot program proposals. However, requiring applicants to have detailed estimates of total eligible and ineligible costs including estimates for the proposed broadband connectivity prior to the applicants knowing the patients participating in the program will result in largely inaccurate cost estimates. In Mercy Virtual's experience, it is difficult to predict with accuracy the cost of providing broadband connectivity to an unknown patient base. This is especially true for the remote and rural patients the pilot program is targeting. While it would be possible for experienced telehealth providers to give average cost estimates based on prior information, there will be significant uncertainty even in these estimates. Mercy Virtual recommends providing overall cost estimates during the

[18] *Connected Care NPRM*, para. 40.

[19] *Id.*, at para. 50.

application phase, then a secondary cost approval during the ramp-up period after the participating patients have been identified. This sequencing would provide greater detail in costs estimates and lower the administrative burden during the application phase, thus promoting greater health care provider participation in the program.

Mercy Virtual recommends a secondary post-application process flow to occur within the six-month ramp-up period for the pilot:

- Identify patients for pilot within defined condition group
- Assess the broadband and equipment needs of the patient base
- Evaluate possible service providers and receive bids for providing broadband service
- Select service provider(s) and file costs with the Commission

This application and cost filing process promotes the Commission's goals of selecting diverse and experienced health care providers while maintaining flexibility for providers to select broadband connectivity plans based on the patients' needs. The application should focus on the health system's record and current ability to reach out to rural/low income populations with the willingness to participate in the pilot. Then, once approved for total cost and scope of the pilot, the health care provider can design an appropriate broadband connectivity plan for the participating patients.

b. Funding Requests and Disbursements

As stated above, Mercy Virtual supports the six month ramp-up period. It is a sufficient period to procure service providers and submit funding requests. This is particularly true for pilots and patients that will be using cellular broadband solutions. It should be noted that pilots seeking to construct or provision fixed broadband connectivity to patients may need a longer period to buildout the connections to the patient population prior to the telehealth service being provided.

In Mercy Virtual's current telehealth programs, Mercy Virtual incurs monthly broadband costs for service and network connectivity. As such, monthly disbursements for recurring service charges would be the most efficient means to offset the health care providers' costs. When Mercy Virtual incurs start-up costs to deploy telehealth services in a new market or deliver a new telehealth service, the initial monetary and labor cost consists of logistics, education, marketing to providers/patients, acquisition mobile devices, and setup of broadband connection/plans. Coordination of all these moving parts will take several months to effectively execute in this pilot program.

VII. The Commission Should Establish Clear Goals and Performance Measures While Balancing the Costs of Randomized Clinical Trials

While the Commission should use clearly stated goals and performance measures to evaluate the effectiveness of the pilot program, the costs of randomized clinical trials may outweigh the benefits for evaluating the program's success. A randomized controlled trial is possible, but only if properly funded as part of this pilot reimbursement. Otherwise, it would be very costly to conduct a randomized controlled trial individually. Clinical trials require dedicated administrative staff and costs to isolate control patient groups from patient groups receiving the subject of the study, maintain records for the two groups, and otherwise administer the trial under strict procedures. This increased administrative costs of running a clinical trial directly reduces the amount of funding that can be utilized to deliver health care to patients. Further, clinical trials are likely unnecessary to value success of the Commission's connected care pilot. Mercy Virtual evaluates the success of its telehealth programs using metrics like length of stay, hospitalization rate, repeat admission rate, emergency visits, and costs savings. The Commission could measure effectiveness through similar metrics without the need of randomized clinical trials to determine success. This would reduce the administrative costs of the pilot programs and increase the amount

of funding available for patient care without lowering the quality of information gathered through the pilots.

VIII. Conclusion

The Commission has taken a laudable and bold step in recognizing the importance of telehealth in the United States. The FCC is uniquely positioned to provide funding for telehealth services and the necessary broadband connectivity and other related expenses that often are barriers to patients in great need who could benefit. Mercy Virtual has extensive experience as a leader and innovator in telehealth services and encourages the Commission to engage with similar health care providers as it establishes the connected care program.

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